

This issue, December First, will greet you with our best wishes and a word from Mr. Canaday and some other material we have dug up that we hope will be interesting to you.

Dear Mr. Canaday:

Just a line to answer your request in the last issue. I am enclosing a clipping from one of the A.A.M.M. papers.

The conditions of which you speak are alarming indeed but the committee on legislation is helpless because the membership will not cooperate. Last month we asked that every member send in the number of people they are serving so that we might be able to say to the legislature that there are so many people in this state who are using massage as a health measure. This is not a request for the names of the people—just the number, how many, and it may be well to include the number of treatments you gave last year as well. This information may be of great help and we only have a short time left to get it worked up. However, practically no one has bothered to comply so we have no choice but to wait until enough of our membership are closed up to awaken the rest to action.

Our President, Mr. Pete Eitreich, is giving us excellent support and assistance as well as leadership. He has made a suggestion we will act on and will report on in our next issue.

Arthur Dunbar

NOTICE

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WASHINGTON CHAPTER OF THE
AMERICAN ASSOCIATION OF MASSEURS AND MASSEUSSES

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Mr. Art Dunbar

Dear Editor:

Just a line to answer your request in the last news, as item No. 2. I am enclosing a clipping from one of the AAMM bulletins, which I believe answers the same. Wish you would put it in the next issue. I wonder why some of our members are trying to evade the issue. I think it time for our federation committee to draft a copy of the law that we have been hearing was for our protection, and a copy sent to each member for their protection. I have been called twice in the last two weeks from a masseur friend who has been visited five times, each time by a different inspector, and they have curbed all his activities, except light, heat and hand massage. When are we going to wake up. I say it is high time now. Lets get the job done now. Tomorrow may be too late. God's word says today is the day of salvation. Today if you will hear His voice, harden not your hearts. This is written in Christian love to all our AAMM members. Lets arise and shine, and protect each other, as there aren't any two of us work just alike, how can we try to separate or define the work of a fellow brother, for all have not the same training, but all have an interest in suffering mankind.

Yours for legislation protection.

Pryor Canaday

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STATEMENT OF POLICY OF THE A.A.M.M.

It is the purpose and aim of the A.A.M.M. and its members to work with, and cooperate with all other healing professions amicably, but to be subserviant to none.

The A.A.M.M. and its members recognize its own limitations, but in the same token is fully aware of its wide field of usefulness in relation to most bodily infirmities.

The A.A.M.M. and its members will recognize and respect all ethical practitioners, and will comply and follow prescriptions sent with referred cases, unless otherwise arranged or modified with the consent of both parties.

The A.A.M.M. and its members reserve the right to accept patients for treatment without prescription, within the full scope of its possibilities, not conflicting with state laws.

CONDITIONS OF THE SACRO-ILIAK JOINT AND THEIR TREATMENT

Considering conditions in the sacro-iliac joint, it would be well to recall one or two anatomical points - the applied anatomy of the sacro-iliac joint. The details of the bone structure are familiar and do not need elaboration. The shape of the sacro-iliac facets or the auricular surfaces are important and significant. Partly in preparation for this talk and partly because I wish to use original observations in my forthcoming book, I studied about fifty sacral bones and gave careful attention to their auricular surfaces. The point which is peculiarly significant is the irregular nature of the surface of the facets. This irregularity is important in our analysis of the movements and of the faulty positions or faulty mobility in the sacro-iliac joints. Only a few have concave surfaces. Some have convex surfaces and most concavo-convex with additional irregularities in the concavo-convex. They are all auricular because they look like the ear, not in their general shape but in their depressions, their convolutions and their promontories. In actual shape they are more like a boomerang with one end shortened. They have a horizontal and a vertical section, neither truly vertical or truly horizontal, but more or less so. The "L" shape of the bend is the opposite of the second sacral level. In men the auricular surface covers the extent of the first, second and third sacral components. In women, it is a smaller joint to allow for movement during pregnancy and confinement. Not only is it smaller, but on the whole it tends to be smoother and less convoluted than in the male. The male pelvis is designed for stability and strength and is more irregular. The corresponding convolutions of the ilium are similar so that they fit into each other. The very irregularity prevents much in the way of movement. The possibility of movement in this joint is interesting. If there were no movement in it the sacro-iliac joint would not, of course, cause any symptoms. The fact that there is no movement in about ninety percent over the age of forty is a significant clinical point because it is rare for the sacro-iliac joint to cause trouble in men over that age. But movement does occur in men under forty and in women to a much lesser age. The interesting point is the range of movement. James Young, an obstetrician of considerable standing, made a study of the sacro-iliac joints during pregnancy and the puerperium. He wondered whether the relaxation that normally occurs during pregnancy can be pathological at any time. In fact, it can. The amount of movement in the ligaments of the pelvis can be excessive at times, and in studying something like three hundred cases, both radiologically and clinically, he found that there was an average increase of width in the symphysis pubis during the first six months of pregnancy. The average increase was 4 mm., expanding from the normal 5 mm. to 9 mm. Now, that increased width must be reflected in the movement of the sacro-iliac joint. If the symphysis is wider, there must have been some corresponding movement in the sacro-iliac joints to cope with it. The posterior superior iliac spines must have become slightly approximated. As you know, the sacro-iliac joint is well posterior in the pelvis. In fact, the posterior superior iliac spines are about a quarter of the distance away from the auricular surface posteriorly as compared with the distance from the auricular surface to the symphysis in front. Now if the symphysis separates by 4 mm. then approximations of the posterior

because there are two sacro-iliac joints, and you can only detect such range of movement there is and how difficult it must be to detect such movement with your fingers over the sacro-iliac joints. But even if it is difficult to detect, it must occur. The plane of the movement must be more or less horizontal or at least in the plane of the pelvic rim. James Young also analyzed the up and down movements of the symphysis pubis. He found that an x-ray of the symphysis showed that standing on one leg, there was a drop: if the weight was taken on the right leg, there was a drop of the os pubis on the left by about 2 mm. There is then a possible up and down movement at the symphysis between the two pubic bones at the symphysis with a range of about 2 mm. Now by mechanics, if there is 4 times the distance from the symphysis to the sacro-iliac joint as compared with the distance from the posterior superior iliac spine and the sacro-iliac joint, then obviously there is only about one half mm. of movement possible in any up and down or rotary movement, so here is another inference that the range of movement in the sacro-iliac joints is extremely small. The facets are irregular and prevent very much movement; but movement does occur, and if a range of movement can occur it can also be restricted. The joint can become fixed conversely - movement can become excessive. The mechanical faults which occur in the sacro-iliac joint then are either hyper-mobility or hypo-mobility. Hypo-mobility is likely to occur mainly during pregnancy and afterwards. After studying patients with x-ray for movement at the symphysis, it was found that in almost all women who had had a confinement, within 3 to 6 months, their range of movement had decreased and returned to normal. Hypo-mobility, therefore, is physiological during pregnancy. But it may become pathologically excessive and it may persist after confinement to cause sacro-iliac pain.

Another way in which the sacro-iliac joints can become excessively mobile is by too much manipulation of the joint. I have seen patients who have had 20 or 30 manipulations of the joint and they had become excessively mobile as a result. It is obviously a sensible thing to avoid manipulating a joint which is already too flexible. It would be foolish to try and manipulate an elbow, for example, which was already hyper-extended; but it is often done in joints in which the range of movement is not so easily detected. I think this applies very much to special joints. In fact, I think that some of the bad results of manipulation are due to manipulating forcefully special joints which are already too flexible. In the spine, leaving the sacro-iliac joint for a moment, you can easily sprain a joint and set up reactive muscular guarding and pain. Now if a joint is restricted, you will usually try to make it mobile again. That would certainly apply if you sprained your ankle; if it were stiff afterwards you would be obliged to move it. But if, say, a 12th thoracic lumbar joint were sprained, there are a lot of other joints above and below it to move. It is quite feasible for the thoracic lumbar joint there to become fixed without the individual being aware of it. Now if that happens in 2 or 3 joints, it is likely that their fixation would be compensated for by a relatively hyper-mobile area above the fixed area and below it. That is a common finding familiar to osteopaths who take care in examining their patients. To manipulate such an area in a loose haphazard way, forcing it in all directions, is a great mistake because it is the flexible joints, the hyper-mobile which will give way first, and not the hypo-mobile. Hence, I would

make a plea for desired examination of the individual joints and detailed and careful manipulation, so that the forces used are designed to release the fixed joints and not those already too flexible. But that is sometimes done. If a forcible movement is made which merely stretches the hyper-mobile joints, obviously the patient's symptoms are going to be worse rather than better for the treatment. The same thing can apply with the sacro-iliac joint. Too much manipulation of this joint, if it is already flexible, will aggravate the symptoms. Hence, the first and foremost thing to determine is which of those states is present, whether in fact there is too much movement or too little. This is not very easy in the sacro-iliac joint because the range of movement is small. There are certain tests, however, which I would like to describe to you which you, with your greater degree of sensitivity as physio-therapists, will be able to appreciate. I use four tests:

The first is a subjective test rather than an objective one - to squeeze the pelvis together. Have the patient lying on the back, hold onto both crests of the ilium, squeeze and force them together, as it were. If there is excessive movement at the sacro-iliac joint, then the patient will describe a sensation and will tell you that there is some pain in one or the other joint. Alternatively, you can attempt to splan the pelvis. Hold the anterior superior iliac spine, dig into the abdomen a little, trying not to prod too hard, and try to separate innomines from one another. In that way, also, you can test for abdominal movement. These tests rely rather on the patient's cooperation than your ability to detect movement. If the joint is relatively or comparatively fixed, these tests will not reveal a fault in the sacro-iliac joint.

The next test is dependent upon tactile ability. Lay the patient on the back and if testing the right sacro-iliac joint, stand on the right side of the table and place the left hand under the patient's pelvis so that the tip of the fingers are on the sacrum and the adjacent parts of the tips of the fingers will be on the posterior superior iliac spine. Place the first and second, perhaps even the third fingers, underneath so that the sacrum and the ilium can be felt together at the same time. When the position is correct - the patient lying on the back and the hand ready to palpate - flex the patient's right knee with your right arm, flex the knee, flex the hip, flex it right up far as it will go and then adduct the femur onto the ilium. The idea is to fix the femur against the innominate in such a way as to make it move as a unit. Then you merely rock the innominate to and fro by leverage on the femur. You can rock into a flexion position, a flexion extension movement, or you can increase the adduction-abduction movement so that there is a very light increased movement. You may then get a sense of the movement between the sacrum and the innominate, and with a lot of practice it is possible to detect a range of movement. It is a 'sense' rather than an actual separation. But with practice you should be able to detect it. Where the joint is hyper-mobile, it is fairly obvious when you test in this way.

- To Be Continued in Next Issue -

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